

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0401	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - STATE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED  09/23/2012
NAME OF PROVIDER OR SUPPLIER  BLEDSOE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 901	<p>1200-8-6-.09(1) Life Safety</p> <p>(1) Any nursing home which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.</p> <p>This Rule is not met as evidenced by: Based on testing and observations, it was determined the facility failed to maintain the general and night lighting system.</p> <p>The finding included:</p> <p>On 9/22/12 at 10:55 AM, testing of the night light in room 105 revealed the light did not work.</p> <p>This finding was acknowledged by the Administrator and verified by the Maintenance Director during exit interview on 9/22/12.</p>	N 901	<p><u>N 901</u></p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>No particular resident was affected.</p> <p>Maintenance replaced the night light in room 105 10/3/12</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>No resident was affected, however all residents have the potential to be affected.</p> <p>Maintenance staff will check resident rooms to ensure all lights are functioning by 11/10/12</p> <p style="text-align: right;"><i>Continued</i></p>	11/10/12	

Division of Health Care Facilities

*Stephanie Bryant*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
STATE FORM

*Administrator* TITLE

(X6) DATE

10/17/12

0890

L8M821

If continuation sheet 1 of 1

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0401	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - STATE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  09/23/2012
NAME OF PROVIDER OR SUPPLIER  BLEDSOE COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 901	<p>1200-8-6-.09(1) Life Safety</p> <p>(1) Any nursing home which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.</p> <p>This Rule is not met as evidenced by: Based on testing and observations, it was determined the facility failed to maintain the general and night lighting system.</p> <p>The finding included:</p> <p>On 9/22/12 at 10:55 AM, testing of the night light in room 105 revealed the light did not work.</p> <p>This finding was acknowledged by the Administrator and verified by the Maintenance Director during exit interview on 9/22/12.</p>	N 901	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Maintenance staff will check resident rooms monthly to ensure all lights are functioning and will replace blown bulbs as needed</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Maintenance staff will check resident rooms monthly to ensure all lights are functioning and will replace blown bulbs as needed.</p>	

Division of Health Care Facilities

*Stephanie Bryant*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Administrator* TITLE

(X6) DATE

10/17/12

STATE FORM

5800

L8M821

If continuation sheet 1 of 1